HEALTH HISTORY
HEALTHY KIDS/HEALTHY MINDS
CHESAPEAKE HEALTH DEPARTMENT

CHILDS INFORMATION

NAME _____ BIRTHDATE _____ SEX/RACE _____

ADDRESS _____ PHONE _____

MOTHER _____ FATHER _____

REFERRED BY _____

PRIMARY CARE PHYSICIAN _____ DENTIST _____

SCHOOL _____ GRADE _____

DOES CHILD HAVE ANY ALLERGIES? _____YES _____NO

_____

LIST ANY PERSONS LIVING IN THE HOME i.e. other children, aunts, uncles, grandparents and cousins:

_____

_____

_____

FAMILY HISTORY:

HAS ANY MEMBER OF THE FAMILY HAD ANY OF THE BELOW ILLNESSES?

_____ASTHMA/BRONCHITIS
_____ANEMIA
_____DIABETES
_____CANCER
_____ALLERGIES
_____HEARING PROBLEMS OR DEAFNESS
_____VISION PROBLEMS/CATARACTS
_____EPILESPY OR SEIZURES
_____HIGH CHOLESTEROL
_____TOBACCO USE

_____HIGH BLOOD PRESSURE
_____STROKE
_____HEART ATTACK
_____MENTAL RETARDATION
_____LEARNING PROBLEMS
_____HEADACHES
_____DEPRESSION
_____ALCOHOLISM OR SUBSTANCE ABUSE
_____THYROID PROBLEMS
_____OTHER

DID YOU EXPERIENCE ANY PROBLEMS DURING PREGNANCY/DELIVERY WITH THIS CHILD?
_____YES _____NO

_____

DEVELOPMENT:

HOW OLD WAS YOUR CHILD WHEN HE/SHE?

_____SAT ALONE _____WALKED ALONE _____TALKED

HEALTH HISTORY:

PLEASE CHECK ANY OF THE FOLLOWING ILLNESSES YOUR CHILD HAS HAD:

_____CHICKENPOX	_____HEADACHES MIGRAINES	_____ASTHMA
_____RUBELLA	_____HEAD INJURIES	_____PNEUMONIA
_____MEASLES	_____VISION PROBLEMS	_____MENINGITIS
_____MUMPS	_____HEARING PROBLEMS	_____VOMITING
_____TUBERCULOSIS	_____EAR INFECTIONS	_____SORE THROATS
_____RHEUMATIC FEVER	_____NOSE BLEEDS	_____HEART MURMUR
_____FREQUENT COLDS	_____TONSILLITIS	_____MUSCLE PAINS
_____LIMPING	_____JOINT PAIN/SWELLING	_____ECZEMA
_____CHRONIC RASHES	_____EASY BRUISING	_____SEIZURES
_____ACNE	_____TOOTHACHES	_____TREMORS
_____DEPRESSION	_____POISONING	_____SHORTNESS OF BREATH
_____PERSISTENT COUGH	_____FREQUENT ABDOMINAL PAIN	_____FAINTING SPELLS
_____CHEST PAINS	_____DIARRHEA/CONSTIPATION	_____BEHAVIOR PROBLEMS
_____ACCIDENT PRONE	_____BLADDER/KIDNEY INFECTIONS	_____LEAD POISONING
_____DIZZINESS	_____BONE PROBLEMS/BROKEN BONES	_____SLEEPING PROBLEMS
_____EATING PROBLEMS	_____SPEECH PROBLEMS	_____LEARNING PROBLEMS

DOES YOUR CHILD TAKE MEDICINE? _____YES _____NO

HAS YOUR CHILD EVER BEEN HOSPITALIZED OR HAD ANY SURGERY OR HAD TO USE THE EMERGENCY ROOM? _____YES _____NO

LEAD SURVEY

5. DOES YOUR CHILD LIVE IN OR REGULARLY VISIT A HOUSE WITH PEELING OR CHIPPING PAINT BUILT BEFORE 1960? (THIS INCLUDES DAY CARE CENTERS, PRESCHOOLS, HOMES OF BABY-SITTERS, RELATIVES ETC.) _____YES _____ NO

5. DOES YOUR CHILD LIVE IN OR REGULARLY VISIT A HOUSE BUILT BEFORE 1960 WITH RECENT ONGOING OR PLANNED RENOVATION OR REMODELING? _____YES _____ NO

5. DOES YOUR CHILD HAVE A BROTHER OR SISTER, HOUSEMATE OR PLAYMATE BEING FOLLOWED OR TREATED FOR LEAD? _____YES _____ NO

5. DOES YOUR CHILD LIVE WITH AN ADULT SHOWS JOB OR HOBBY INVOLVES EXPOSURE TO LEAD? (SUCH HOBBIES INCLUDE CERAMICS, FURNITURE REFINISHING AND STAINED GLASS WORK.) _____YES _____ NO

5. DOES YOUR CHILD LIVE NEAR AN ACTIVE SMELTER, BATTERY RECYCLING PLANT, OR OTHER INDUSTRY LIKELY TO RELEASE LEAD? _____YES _____ NO

_____
SIGNATURE OF NURSE